U.S. Representative

John Spratt

South Carolina ■ 5th District

News Release

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Spratt Backs New Medicare Prescription Drug Bill

WASHINGTON — U.S. Rep. John Spratt (D-SC) today announced his strong support for the unified Medicare prescription drug bill unveiled today, which he said will address the real problems affecting senior citizens in South Carolina.

"When Medicare was created in 1965," said Spratt, "prescription drug coverage was not a standard feature of private insurance policies. As a result, nearly 13 million Medicare recipients who have no supplemental drug coverage pay for their prescription drugs out of their own pocket, often at outrageous prices. Overall, it has been estimated that nearly two-thirds of Medicare beneficiaries have no drug coverage or unreliable, costly, and limited coverage and must pay these drug costs out-of-pocket.

"Prescription drug coverage for older Americans is one of the most serious issues facing this Congress. Unfortunately, the Republican leadership has spent the last year blocking prescription drug legislation. I hope that this new bill will break down the walls of resistance — and succeed in bringing up some sort of bi-partisan prescription drug bill to the floor of the House.

"Now is the time to act," said Spratt. "Democrats in Congress have introduced strong, common-sense legislation to address America's prescription drug crisis and help seniors avoid having to choose between buying groceries or taking the medication their doctors prescribe. We must not wait any longer. We must join together in a bi-partisan way to address this crisis."

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A list of major features of the House Democratic proposal accompanies this release.

MEDICARE PRESCRIPTION DRUG ACT OF 2000

Major Features of the House Democratic Proposal

Universal, Voluntary. Establishes a voluntary Prescription (Rx) Drug Benefit Program for seniors and disabled in Medicare (called Part D), beginning in 2002.

Eligibility and Enrollment. Enrollment is voluntary when a senior or disabled person first becomes eligible for Medicare, or if and when they lose coverage from an employer, Medicare+Choice plan, or Medicaid.

Coverage. Enrollees (1) receive Medicare payment for covered drugs from any participating pharmacy and (2) are charged negotiated, discounted prices on all their covered drug purchases regardless of whether the annual benefit limit has been reached. The program covers FDA-approved drugs, including immunosuppressive drugs. Beneficiaries are guaranteed coverage for any covered drug their doctor prescribes.

Benefits. Medicare, through a Rx Drug Insurance Account, will pay for at least 50% of the negotiated price for the drug, up to 50% of annual limits equal to $2000 in 2002-2004, $3000 for 2005-6, $4000 for 2007-8, and $5000 for 2009, and for succeeding years, the previous yearís limit adjusted for inflation. If the benefit providers achieve greater than anticipated discounts, the savings can be used to decrease the beneficiariesí 50% copay. Each year, the Secretary determines the premium amount necessary to pay no more than half the benefit cost.

The Secretary by 2002 implements (through private sector benefit providers) a catastrophic benefit limiting a beneficiaryís maximum out-of-pocket costs to approximately $3000 per year adjusted for inflation.

Private Sector Administration. The Secretary shall contract with a private benefit provider in various designated geographic areas. Benefit providers are any entity the Secretary determines can fulfill the contract. The Secretary is prohibited from establishing a formulary or setting prices.

Ending Price Discrimination. In order to ensure that drug prices are equitable and affordable to beneficiaries, the private benefit providers are charged with using Medicareís volume purchasing power to negotiate and achieve the same drug price discounts that favored large purchasers obtain. Benefit providers shall use proven market-based strategies to negotiate prices for Rx drugs that eliminate unfair price discrimination against seniors.

Other Duties of Private Benefit Providers. Benefit providers shall ensure convenient access to physician prescribed drugs through distribution systems and work with local pharmacies to establish drug utilization review, quality improvement and error reduction programs. Benefit providers are also responsible for patient confidentiality standards and ensuring beneficiary grievance and independent appeals procedures.

Participating pharmacies must meet licensing, access, quality, and confidentiality requirements and not balance bill beneficiaries.

General Accounting Office Oversight. The GAO will monitor the success of benefit providers in achieving through price discounts the prices paid by favored large purchasers, assuring access by all beneficiaries to drugs prescribed by doctors, improving quality and reducing errors, ensuring patient record confidentiality, and meeting other contract requirements.

Employer Incentive Program. Employers providing drug coverage equal to or better than the Medicare coverage receive an incentive payment to maintain such coverage.

Low-Income Protections. Beneficiaries up to 135% of poverty would receive full assistance with premiums and cost sharing. Between 135 and 150% of poverty, beneficiaries would receive assistance with premiums on a sliding scale.

Guaranteed Rural Access. The Secretary is instructed to ensure residents in rural areas have full access to all benefits.

Studies and Medicare Payment Advisory Commission. MedPAC is expanded from 17 to 19 Commissioners to allow the appointment of 2 experts in the pharmaceutical delivery area. Studies will be conducted on ways to encourage pharmaceutical R&D, identify public R&D subsidies to the industry, assess industry sales practices, and explain differences in US and developed country drug prices.

Medicare Coverage of Self-Administrable Drugs. In 2001, Medicare reforms will encourage cost-saving substitution of self-administrable drugs.